UNIFORM ADVANCE DIRECTIVES FORM FOR A NURSING HOME RESIDENT
(*Complies with R.I. Gen. Laws § § 23-4.13-1 et seq.- Right of the Terminally Ill Act– Living Will***)**

Section 1 ***(Required for document to be valid by law)***

I, (print name)_____, am a competent individual eighteen (18) years of age or older and being of sound mind willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare: If I should have an incurable or irreversible condition that will cause my death and if I am unable to make decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw procedures that merely prolong the dying process and are not necessary to my comfort, or to alleviate pain. I may change my decision and fill out another Living Will at anytime.

Section 2 ***(Optional- Not required by law))***

You may tell the health care providers what you think your present medical condition is and what is important to how you live your life.

My present medical condition is: _____

_____

Section 3 ***(Optional- Not required by law)***

You have right to control decisions relating to your health care. Section 2 permits you to describe to your health care providers the treatment options you may prefer. You are not required to answer questions in Section 2; however, the information in Section 2 will help your health care provider give you the kind of medical treatment you want. You may fill out this form with the help of family, health care provider, or anyone else you would like to help you. Please initial and check the box next to your preference for the following medical orders and treatments. Please check only one (1) box for each question.

1A. If I suffer an incurable or irreversible condition that will cause death and my heart stops and I stop breathing,

q I do **not** want CPR (breathing and chest pressing) to try to restart my heart and breathing. ____ *Initials*

OR

q I want CPR (breathing and chest pressing) to try to restart my heart and breathing. _____ *Initials*

1B. If you want CPR, you may be more specific about the CPR measures you want. **Please check and initial the types of CPR you want in Section 1B:**

q If my heart does not start with CPR, I want electrical stimulation to try to restart my heart and breathing. _____*Initials*

q If my heart does not start with CPR, I want drugs to try to restart my heart and breathing. ____*Initials*

2. If I suffer an incurable or irreversible condition that will cause death and I cannot breath on my own,

q I want to be assisted in breathing by a tube inserted in my throat called intubation and using a machine called a respirator or ventilator. _____ *Initials*

OR

q I do **not** want assistance in breathing by intubation or machine. _____ *Initials*

Explanation, if any: _____

3. If I suffer an incurable or irreversible condition that will cause death and I have difficulty breathing,

q I want to be made comfortable by the use of oxygen to help me breath. _____ *Initials*

OR

q I do **not** want to be made comfortable by the use of oxygen to help me breath _____ *Initials*

Explanation, if any: _____

3A. If I suffer an incurable or irreversible condition that will cause death and I experience pain,

q I do **not** want my pain managed and treated if the medication affects my alertness. _____ *Initials*

OR

q I want my pain managed and treated even if the medication affects my alertness. _____ *Initials*

3B. You may tell the health care providers how aggressively you want you pain managed. **Please check and initial the types of pain management you want in Section 4B:**

q I want my pain managed and treated even if the medication effects my ability to interact. _____ *Initials*

q I want my pain managed aggressively even if the medication effects my alertness. _____ *Initials*

Explanation, if any:

_____

4. If I suffer an incurable or irreversible condition that will cause death and I develop an infection,

q I want to be treated with antibiotics. _____ *Initials*

OR

q I do **not** want to be treated with antibiotics. _____ *Initials*

Explanation, if any: _____

5. If I suffer an incurable or irreversible condition that will cause death and I cannot take or eat food by mouth,

q I want an artificial feeding tube. _____ *Initials*

OR

q I do **not** want an artificial feeding tube. _____ *Initials*

Explanation, if any: _____

6. If I suffer an incurable or irreversible condition that will cause death and I become dehydrated,

q I want to be given intravenous hydration. _____
OR *Initials*

q I do **not** want to be given intravenous hydration. _____
Initials

Explanation, if any: _____

Section 4 ***(Optional- Not required by law)***

Preference for Place of Treatment:

Please check and initial if you prefer to stay in the nursing home, if possible, rather than be treated in hospital.

q _____ If I become ill or injured and live in a nursing home, I prefer to stay in the nursing
Initials
home rather than be treated at the hospital, if the nursing home can appropriately diagnosis and treat my illness or injury.

q _____ If I develop an incurable or irreversible condition, I prefer to stay at the nursing home
Initials
rather than be tranferred to a hospital, unless the nursing home can't provide for my comfort.

Section 5 ***(Optional-Not required by law)***

Religious and Spiritual Requests:

Do you want your Rabbi, Priest, Clergy, Minister, Imam, Monk, or other spiritual leader contacted if you become sick or at the end of your life?

_____ Yes No
Initials

Name of Rabbi, Priest, Clergy, Minister, and Imam _____
Address:_____
Phone Number: _____

Section 6 (Required by law to be valid)

Signatures:
Resident/Declarant:

Signature _____

Address _____

Signed on _____

Statement of Witnesses

The Declarant is personally known to me and voluntarily signed this document in my presence. I am not related to the Declarant by blood or marriage.

_____	_____
Witness	Witness
_____	_____
Address	Address
Signed on_____, _____.	Signed on_____, _____.

Section 7 (*Optional- Not required by law)*

You are not required to give anyone your Uniform Advance Directives Form, but if it cannot be found at the time you needed it, it cannot help you. For example, you are unable to participate in making health care decisions and you put your Uniform Advance Directives Form in a safety deposit box, the physician and other health care providers will not have access to it and they will not be able to respect your medical treatment wishes.

You should give copies of the Uniform Advance Directives Form to your physician and nursing home so that it can be attached to your medical record, just in case it is needed. Please check who you gave copies to of your Uniform Advance Directives Form and provide their name, address, and phone number.

(Name) (Address) (Phone)

q Nursing Home _____

q Physician _____

q Physician _____

Below is a list of some people that you may want to give a copy of your Uniform Advance Directives Form other than health care providers. Please provide the name, address, and phone number for persons you give your Uniform Advance Directives Form.

(Name) (Address) (Phone)

q Family _____

q Family _____

q Lawyer _____

q Others _____

q Others _____

Section 8 ***(Optional- Not required by law)***

Physician/Staff Acknowledgement:

I, _____, discussed the Uniform Advance Directives Form for Nursing Home Residents, prior to the resident's signing it.

_____ _____

Signature of Physician/Staff who discussed the Uniform Advance Directives Form Date

Section 9 ***(Optional- Not required by law)***

Preferences after death

My wishes about what happens to my body when I die (cremation, burial):

_____

_____

_____

Final Pilot Ver.